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The following comments evolve from two assumptions:

- (1) The "problem" to be solved is how to cope with catastrophic medical expenses.

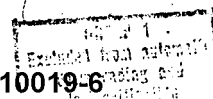
and

- (2) The solution is insurance.

Within this frame of reference, the following comments still do not offer a remedy for the catastrophic who has a plan of health insurance other than the Agency's Association Benefit Plan (over which we have no control of benefits or rates) nor do they speak to the relatively few employees who may have no health insurance at all.

*WAB*

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## THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

The Federal Employees Health Benefits Program was created in 1959 by Public Law 86-382. It provides for a variety of health insurance plans to be made available to federal employees with the government bearing a portion of the premium cost. Types of plans provided for are:

- Government-wide Service and Indemnity Benefit Plans  
(Blue Cross-Blue Shield and Aetna)

- Employee Organization (Union) Plans

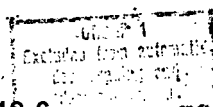
- Individual and Group Practice Comprehensive Plans  
(Serving specific cities or geographic areas)

The program is administered by the U. S. Civil Service Commission and the Commission contracts for benefits and rates with the participating plans as well as establishes regulations concerning eligibility, enrollment procedures, permissible changes in enrollment, etc.

## THE AGENCY'S ASSOCIATION BENEFIT PLAN GEHA

The Agency's health insurance plan, the Association Benefit Plan, is one of 41 plans which participate in the Federal Employees Health Benefits Program and as such is subject to the provisions of law and federal regulations pertaining to that program. Through the sponsoring organization known as Government Employees Health Association, Inc.

(GEHA), Agency employees annually negotiate the benefits and rates that



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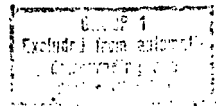
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are part of a contract between GEHA and the U. S. Civil Service Commission. Benefits and rates are on a calendar year basis and any proposed changes must be submitted to the Commission by 31 August of the preceding year. GEHA does not "self-insure" but rather has a policy with Mutual of Omaha to underwrite the total Plan and to pay the claims of overt retirees. (Claims of all employees, overt or covert, are processed within the Agency by Agency personnel.) Under these agreements, i. e., between GEHA and the Commission, and between GEHA and Mutual of Omaha, neither GEHA nor Mutual of Omaha is likely to make or lose large sums of money. Mutual is limited to a risk charge and commission of 2.08% of the gross premium, plus actual administrative expenses. GEHA is limited to administrative (salary) expenses. Any premiums in excess of claims expense, plus administrative expense, plus risk charge-commission, constitute a special reserve for the exclusive use of GEHA's Association Benefit Plan to increase its benefits or forestall a rate increase. A substantial loss by Mutual is unlikely since one year's loss will be offset by increasing the following year's premium rate.

GEHA attempts to maintain Association Benefit Plan benefits comparable to those of the two government-wide plans while at the same time keeping premiums at or below the cost of these plans. This is considered essential since enrollment in the ABP is required of all

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employees under cover. Because the ABP is an experience rated plan any increased claims expense, including that due to benefit liberalization, must be borne by the ABP's own enrollees through increased premium. Any benefits that are increased are translated by the underwriter's actuaries into anticipated annual increase in claims dollars and premiums will be adjusted accordingly. We must pay the full price of everything we ask for. Bearing this in mind, consideration could be given to the following:

#### INCREASES IN BENEFITS OF AGENCY'S HEALTH INSURANCE PLAN

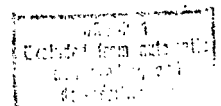
1. Increase the ABP co-insurance factor from 80% to some greater percentage. This is hardly an appropriate remedy since it would raise the benefits of everyone in the Plan rather than just the catastrophic cases. It would therefore have an expensive price tag.

2. Increase the ABP insurance benefit from 80% to full coverage after X thousands of dollars in major medical benefits have been paid in a calendar year. This is a variation of 1 above but it does not take effect until the patient becomes a catastrophic case. It would apply to the few who need it the most and therefore would be less costly *than 1. above*

3. Add a "handicapped benefit" similar to CHAMPUS program\* to the ABP. This would have very limited, specific application, is costly,

\*The CHAMPUS Handicapped program is not Utopia. It limits benefits to a maximum of \$350 per month and requires the patient's sponsor to pay some part of the monthly cost according to his grade.

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and it is questionable if underwriter could be persuaded to underwrite.

4. Initiate a "Handicapped Plan" on its own. It is doubtful if anyone would underwrite such a program. Also doubtful if anyone other than employees who already have handicapped family members would enroll. This course of action would have a high risk of extreme adverse selection against such a plan.

5. Increase the ABP maximum major medical benefit from current \$30,000. <sup>to say, \$50,000</sup> Probably the most feasible change. Will involve only the catastrophic few who need it.

6. Increase the number of days (presently 90) during which Basic Benefits are paid for hospital expenses.

*all items 1 thru 6 would increase premium for all employees,*

*(item 5 looks good and premium increase negligible - should be coupled with ability to change plans every year on birth date rather than every three years - would require CSC ruling change, <sup>to</sup> and law governing CSC plans annually.*

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Excluded from automatic  
downgrading and  
declassification